PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12086 P

Reg. Dist. No. 7C

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? less than 24 hours
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? less than 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk (If outside city or town limits, write RURAL and give nearest town)
Street No.: 27 Seabright Avenue (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ~~Arthur Adams~~ WILLIAM ARTHUR ADAMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Adams

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): ~~Not known~~ June 30, 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
72	5	12		

9. Birthplace: Bedford County, Pennsylvania (Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business: ---

FATHER
12. Name: Not known
13. Birthplace: Not known

MOTHER
14. Maiden name: Anna Kensinger
15. Birthplace: Not known

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-15-45 (month) (day), (year)
Cemetery or crematory: Oaklawn Cemetery
Location: Eastern Avenue
18. Funeral director: Wendell E. Humphreys
Address: 6067 Harford Rd

19. 12/14 1945 Arb. Hedrick Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1945 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11 1945, to December 11 1945 (less than 24 hours) and that I last saw h... alive on December 11 1945

Immediate cause of death	DURATION
Broncho-Pneumonia	5 hours
Due to	
Due to	
Other conditions Psychosis c Organic brain Disease	5 weeks

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other
Address: Springfield Hosp. Sykesville, Md. Date signed: 12-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

12087

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred: Springfield State Hospital (employee)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Springfield State Hospital
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harry Fessler Baer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ruth Elizabeth Dallmus
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): December 15, 1871

8. AGE: Years	Months	Days	If less than one day
74	--	3	...hrs. ...min.

9. Birthplace: Tannery, Carroll County, Md. (Town, county, and state)
10. Usual occupation: Physician, mental diseases
11. Industry or business: State Mental Hospital

FATHER
12. Name: James Shellman Baer
13. Birthplace: Baltimore City, Maryland

MOTHER
14. Maiden name: Susan Kimball Fessler
15. Birthplace: Frederick, Maryland

16. Informant: Mrs. Ruth Baer (widow)
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Dec. 20, 1945 (month) (day) (year)
Cemetery or crematory: Springfield Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Wees
Address: Sykesville, Md.

19. Dec. 19 1945 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18 1945, at 5:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1943, to Dec. 18 1945
and that I last saw him alive on December 18 1945

Immediate cause of death	DURATION
Coronary occlusion	18 days
Due to: Arteriosclerosis, more than 2 yrs.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 12-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

12088

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 7 mos.
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yrs 7 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1107 Division
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William H. Baer.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6 1890

8. AGE:

Years	Months	Days	If less than one day
55	5	20	hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business

FATHER
12. Name: Charles Baer
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Ruth Lynch
15. Birthplace: Baltimore Md.

16. Informant: Josephine Reese
Address: Reisterstown Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12/28/45 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem.
Location: 7225 Easton Ave.

18. Funeral director: John J. Gowan & Son
Address: 901-03 Hollins Street

19. 12/25 1945 A W Hedrick adk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1945, at 5.40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1945, to Dec 25 1945, and that I last saw him alive on Dec 23, 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	6 mos.
Chronic Interstitial Nephritis	
Due to: Generalized Arteriosclerosis	6 mos.
Due to:	
Other conditions: Pelvic Osteomyelitis, Paranoia	5 years

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Kenneth C Jones M. D. or other
Address: Reisterstown Md Date signed: 12/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

12089

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Gamber
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Gamber
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Earl LeRoy Barnes

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 2, 1901

8. AGE: Years: 44 | Months: 7 | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: labor

11. Industry or business

FATHER
12. Name: R. Hanson Barnes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma A. Yingling
15. Birthplace: Maryland

16. Informant: Mrs. Charles L. Caltrider
Address: Gamber, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12/22/45 (month) (day) (year)
Cemetery or crematory: Calvary Cemetery
Location: Gamber, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 12/21/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 19 45, at 11 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 20 19 45, to December 20 19 45
and that I last saw h... alive on December 20 19 45

Immediate cause of death	DURATION
Acute Alcoholism -	1 week
Due to: Exposure to freezing Weather	12 hours
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other
Address: Westminster Md. Acting Deputy Med. Exam. Date signed 12/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

12690

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs. 5 mos. 13 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Sykesville, rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ernest Norris Bennett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 3, 1910

8. AGE: Years	Months	Days	If less than one day
35	5	11	..... hrs. ..... min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: George A. Bennett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hattie Leatherwood
15. Birthplace: Maryland

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 17 1945 (month) (day) (year)
Cemetery or crematory: Oakland Methodist Cem.
Location: Mt. Oakland Mills, Carroll Co. Md.
18. Funeral director: C. Harry Eiler
Address: Sykesville, Md.
19. Dec. 15 1945 (Date rec'd by registrar) C. Harry Eiler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 19 45 at 7:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 19 45 to Dec. 14 19 45 and that I last saw him alive on December 14 19 45

Immediate cause of death	DURATION
Bronchopneumonia (terminal)	8 hours
Due to: Osteomyelitis, of right elbow, chronic	5 days
Due to:	
Other conditions: Schizophrenia, Catatonic type	8 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other
Address: S. S. Hosp. Sykesville Md. Date signed 12-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12691

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll.

City or town: Manchester R.D. #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Carroll.

City or town: Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Manchester Md R.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Granville Bish

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie Rebecca Stansbury

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Nov 9 1874

8. AGE:

Years	Months	Days	If less than one day
71	1	20	..... hrs. ..... min.

9. Birthplace: Carroll, County Md. (Town, county, and state)

10. Usual occupation: Retired Farmer 6 years.

11. Industry or business

MOTHER

12. Name: Westley Bish

13. Birthplace: Carroll County Md.

FATHER

14. Maiden name: Eliza Wenty

15. Birthplace: Carroll. County Md.

16. Informant: Mrs. Irene R. Bish

Address: Manchester Md R.D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 2 1946 (month) (day) (year)

Cemetery or crematory: St. Bartholomews Church.

Location: Hanover Pa R.D. York County

18. Funeral director: W. A. Fesser

Address: Hanover Pa.

19. Dec 30 1945 (Date rec'd by registrar) Mrs. W. G. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1945, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fracture Cervical Vertebrae	
Due to: Automobile accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Dec 29-45

Where did injury occur? Nr Manchester (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Route 30

Means of injury: Automobile accident Injured at work? No

23. SIGNATURE: T. Monk Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed: 12-29-45

12092

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 5 months, 11 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: DANIEL LEWIS BISHOP

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 15, 1927

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
18	10	24		

9. Birthplace: Snow Hill, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business

FATHER — 12. Name: Daniel Bishop
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Ella Bishop
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-45 (month) (day) (year)
Cemetery or crematory: Snow Hill
Location: Snow Hill md'
18. Funeral director: Pearre & Dennis
Address: Snow Hill md.

19. Dec. 9, 19 45 (Date rec'd by registrar) Albert L. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9, 1945, at 6:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28, 1943, to Dec. 9, 1945
and that I last saw him alive on Dec. 9, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 12-9-45

12094

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years Approx.
Hospital, institution, or street address where death occurred: 77 W. Green St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 77 W. Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Matilda Bixler

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widowed

6.(b) Name of husband or wife: George A. Bixler
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 4, 1860

8. AGE:

Years	Months	Days	If less than one day
85	11	18	hrs. min.

9. Birthplace: Warfieldsburg Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: Levi Barnes
13. Birthplace: Carroll Co. Md.
MOTHER 14. Maiden name: Matilda ?
15. Birthplace: Carroll Co. Md.
16. Informant: Mrs. Paul S. Bixler
Address: 77 W. Green St. Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/45 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Maryland
18. Funeral director: J. E. Myers Jr.
Address: Westminster Md.
19. 12/23/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 22 19 45; at 11:20 A.M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from April 1st 19 45 to Dec 22 19 45
and that I last saw her alive on or about Dec 22 19 45
Immediate cause of death: Organic Heart Disease — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John L. Stewart M. D. or other
Address: Westminster Md. Date signed: Dec 22 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12093

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos. 9 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 4 mos. 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, (If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Julia Bochniak

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Andrew Bochniak

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 17, 1919

8. AGE: Years	Months	Days	If less than one day
26	0	17	hrs. min.

9. Birthplace: New Jersey (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John Murowski

13. Birthplace: Poland

MOTHER — 14. Maiden name: Mary Sasinowski

15. Birthplace: Poland

16. Informant: Records of Springfield State Hospital, Sykesville, Md.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 7/45 (month) (day) (year)

Cemetery or crematory: St Stanislaus

Location: Baltimore

18. Funeral director: Fred W Orazewski

Address: 1980 Eastern Ave.

19. 12/6 19 45 A. W. Bedrud Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 19 45 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 25 19 45 to Dec. 4 19 45; and that I last saw her alive on Dec. 4 19 45

Immediate cause of death	DURATION
Chronic fibrous pulmonary tuberculosis, far advanced	Nov 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Ellis L. Margolin M.D. M. D. or other

Address: Sykesville, Md. Date signed: Dec 5, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

12095 81

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town)

Street No.: Main Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Emory Scott Boone

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife: Alice Boone

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 19 1865

8. AGE: Years	Months	Days	If less than one day
80	3	11	hrs. min.

9. Birthplace: Frederick County Maryland (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: Retired

FATHER — 12. Name: Scott Boone

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lydia -------

MOTHER — 15. Birthplace: Not Known

16. Informant: Kernie R Boone

Address: 1225 W.King St York Penna

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 2 1945 (month) (day) (year)

Cemetery or crematory: Beaver Dam Cemetery

Location: near Union Bridge Maryland

18. Funeral director: D.D.Hartzler & Sons

Address: Union Bridge & New Windsor Md

19. Dec 31 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1945 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 19[illegible] to Dec 30 19[illegible]

and that I last saw h[illegible] alive on Dec 30 19[illegible]

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J H Legg M.D. M. D. or other

Address: Union Bridge Date signed: 12-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12096

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 5 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JAMES WILLIAM BROWN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 12, 1885

8. AGE: Years	Months	Days	If less than one day
60	5	28	hrs. min.

9. Birthplace: Germantown, Md.
(Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business

FATHER
12. Name: Jonas Brown
13. Birthplace: Maryland

MOTHER
14. Maiden name: Liza Lee
15. Birthplace: Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/11/45 (month) (day) (year)
Cemetery or crematory: Brownstown Cemetery
Location: Jerusalem Rd.
18. Funeral director: P. C. Gartrell
Address: Gaithersburg Md.

19. Dec. 10, 1945 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10, 1945, at 7:45P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5, 1945 to Dec. 10, 1945 and that I last saw him alive on Dec. 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed 12-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12097

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos., 20 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium (Colored)
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Hardela Springs, R.R.1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Juanita Brown

3.(b) Social Security Number 213-14-6807

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1919

8. AGE: Years	Months	Days	If less than one day
25	1	3	..... hrs. ..... min.

9. Birthplace Hardela Springs, Md.
(Town, county, and state)
10. Usual occupation domestic
11. Industry or business

FATHER
12. Name Charles O. Brown
13. Birthplace Maryland

MOTHER
14. Maiden name Ruth Hufferton
15. Birthplace Maryland

16. Informant Reuben Hoffman, M.D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 27, 1945 (month) (day) (year)
Cemetery or crematory Fredericksburg
Location Fredericksburg, Md.
18. Funeral director J. Thornton & Son
Address Fredericksburg, Md.

19. Dec. 24 1945 (Date rec'd by registrar) Albert R. Sherman deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1945 at 9:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945 to Dec. 24 1945 and that I last saw her alive on December 24 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	Jan. '45
Due to	
Due to	
Other conditions	
Premature delivery 11-6-45	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman M.D.
M. D. or other
Address Henryton, Md. Date signed 12-27-45

12098

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 5 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 347 Cannon Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JAMES ALBERT BURGESS

3.(b) Social Security Number: 218-16-8101

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 19, 1923

8. AGE:	Years	Months	Days	If less than one day
	22	1	14	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: John Burgess
13. Birthplace: Maryland

MOTHER
14. Maiden name: Caroline Barrell
15. Birthplace: Kent County, Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 7 1945 (month) (day) (year)
Cemetery or crematory: Chestertown
Location: Chestertown, Md.
18. Funeral director: Marvin D. Williams
Address: Chestertown, Md.

19. Dec. 3, 19 45 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3, 1945, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28, 1945 to Dec. 3, 1945 and that I last saw him alive on Dec. 3, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed 12-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12099

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years and 3 months
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 24 years and 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Pinto
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ANNA BYRD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: (unknown) Byrd
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 28, 1866

8. AGE: Years	Months	Days	If less than one day
79	6 mo	29	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Emanuel Mills
13. Birthplace: Allegany Co. Md.

MOTHER
14. Maiden name: unknown
15. Birthplace: Allegany Co. Md.

16. Informant: Hospital Records
Address: Sykesville, Maryland.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Jan. 5, 1946 (month) (day) (year)
Cemetery or crematory: Springfield State Hospital
Location: Sykesville, Md.
18. Funeral director: C. Harry Eiler
Address: Sykesville, Md.
19. Jan. 5 1946 (Date rec'd by registrar) C. Harry Eiler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 1945 at 9.45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-19-1921 to 12-27-1945 and that I last saw h[illegible] alive on December 26 1945

Immediate cause of death	DURATION
Ceberal Arteriosclerosis	7 yrs.
Due to	
Due to	
Other conditions Paranoid condition	24 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Maud M. Ross M D
M. D. or other
Address: Sykesville Md. Date signed 12-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12100

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 32 S. Poppleton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Hannah Josephine Chatterton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Ira Chatterton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 1872

8. AGE: Years	Months	Days	If less than one day
73	10	?	hrs. min.

9. Birthplace: Alexandria, Va.
(Town, county, and state)
10. Usual occupation: Seanstress
11. Industry or business:

FATHER
12. Name: John Merritt
13. Birthplace: Alexandria, Va.

MOTHER
14. Maiden name: Virginia Cawood
15. Birthplace: Alexandria, Va.

16. Informant: Records of Springfield
Address: State Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/14/45 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Old Frush Road
18. Funeral director: John J. Conway Son
Address: 901-03 Hillen St.

19. (12/13) (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11 1945, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1945 to Dec. 11 1945 and that I last saw her alive on Dec. 11 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	5 years
Due to:	
Due to:	
Other conditions: Arteriosclerosis	5 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alex Kamm M.D.
M. D. or other
Address: Springfield State Ho. Date signed: Dec. 11

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12101

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years, 4 months, 9 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 8 years, 4 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1727 Ashland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ray Ruth Cohen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 14, 1895

8. AGE: Years	Months	Days	If less than one day
50	3	23	hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual occupation: sales lady
11. Industry or business

FATHER
12. Name: Welfe Cohen
13. Birthplace: unknown

MOTHER
14. Maiden name: Sarah Mosquille
15. Birthplace: unknown

16. Informant: Hospital record
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1945 (month) (day) (year)
Cemetery or crematory: Ruth Hebrew Cem.
Location: Washington Blvd.

18. Funeral director: Jack Lewis, Inc.
Address: 216 Eutaw Place

19. Dec. 7 1945 (Date rec'd by registrar) Harry Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7 1945 at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1942 to December 7 1945 and that I last saw her alive on December 7 1945

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to	
Other conditions: Dementia praecox	18 years

(Include pregnancy within 3 months of death)

Major findings of operations: Tracheotomy Date of op. July 1927
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hitchcock, M.D.
M. D. or other
Address: Springfield State Hosp. Date signed 12-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12102

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 26 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 mos. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8400 Georgetown Road
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Thomas H. Collins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nellie L. Collins

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 10, 1859

8. AGE: Years	Months	Days	If less than one day
86	2	11	____ hrs. ____ min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business:

FATHER
12. Name: James A. Collins
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Susan Banner
15. Birthplace: North Carolina

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec 21 1945 (month) (day) (year)

Cemetery or crematory: Bethesda Md

Location:

18. Funeral director: Wm R. Pumphrey
Address: Bethesda Md.

19. Dec. 21 1945 (Date rec'd by registrar) C. Henry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 1945, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 25 1945, to Dec. 21 1945, and that I last saw h. im alive on Dec. 21 1945.

Immediate cause of death	DURATION
Bronchopneumonia (terminal)	12 hrs.
Due to: Cerebral hemorrhage	3 days
Due to: Generalized arteriosclerosis	
Other conditions: Senile Psychosis, Paranoid type.	2 years

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Arnold K. Eichert M.D.
M. D. or other

Address: S.H. Hosp. Sykesville Md. Date signed 12-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12103

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co. Md
City or town: Westminister
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months.
Hospital, institution, or street address where death occured:
219 E. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro iofants give resideoce of mother)
State: Md. County: Carroll
City or town: Westminister
(If outside city or town limits, write RURAL and give nearest town)
Street No. 219 E. Main St.
(If roral, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William J. Cordle (CORDLE)

3.(b) Social Security Number: 212-09-4151

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

6.(b) Name of husband or wife: Anne Cremen Cordle
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb. 21, 1889

8. AGE: Years	Months	Days	If less than one day
56	10	8	...hrs. ...min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Machanic
11. Industry or business: Auto Shop
FATHER 12. Name: Wm. J. Cordle
13. Birthplace: Richmond, Va.
MOTHER 14. Maiden name: Catherine Smith
15. Birthplace: Knoxville, Tenn.
16. Informant: Mrs. Anne Cordle
Address: 219 E. Main St. Westminister
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/46 (month) (day) (year)
Cemetery or crematory: Cathedral Cem.
Location: Baltimore, Md.
18. Funeral director: C. Vernon Lemmon
Address: 4611 Park Heights Ave.
19. 1/2/46 (Date rec'd by registrar) Balto. City Cathedral Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29-45 at 10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28- 1945 to Dec 29-1945
and that I last saw him alive on Dec-29- 1945

Immediate cause of death	DURATION
Myocarditis (chr)	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Jesmer M.D.
Address: Westminster Date signed: 12-30-45
M. D. or other

Dr. Jeannett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12104

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 4 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 548 West Barre Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SANFORD DAVIS

3.(b) Social Security Number: 214-01-4818

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 7, 1888

8. AGE: Years	Months	Days	If less than one day
57	0	7	hrs. min.

9. Birthplace: Louisburg, N.C. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Samuel Davis
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Leah Harris
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/16/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A A Co Md
18. Funeral director: Isaac L Brown Son
Address: 1086 Montgomery Street

19. Dec. 14, 1945 (Date rec'd by registrar) Albert R Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14, 1945, at 4:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1944, to Dec. 14, 1945
and that I last saw him alive on Dec. 14, 1945

	DURATION
Immediate cause of death: Tuberculous Meningitis	Nov. 27, 1945
Due to: Pulmonary Tuberculosis	Jan. 1944
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 12-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12105

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 16 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Turners Station,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 Linden Court
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ROBERT LEE DAY

3.(b) Social Security Number: 220-14-2417

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9, 1928

8. AGE:	Years	Months	Days	If less than one day
	17	3	18	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Scholar

11. Industry or business

FATHER
12. Name Benjamin Day
13. Birthplace Virginia

MOTHER
14. Maiden name Alverta Diggs
15. Birthplace Virginia

16. Informant Reuben Hoffman, M.D.
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31, 1945 (month) (day) (year)
Cemetery or crematory Arbutus Memorial
Location Baltimore, Co. Md.

18. Funeral director Mrs. Geo. H. Holland.
Address 1631 Druid Hill ave.

19. Dec. 27, 19 45 (Date rec'd by registrar) Albert R. Swadley Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 19 45 at 2:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11, 19 45 to Dec. 27, 19 45 and that I last saw him alive on Dec. 27, 19 45

Immediate cause of death Pulmonary Tuberculosis — DURATION 9-15-45

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 12-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

12106

Reg. Dist. No. 14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 9 days.
Hospital, institution, or street address where death occurred:
Springfield State Hosp.
How long in hospital or institution? 1 mo., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4608 Hunt Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gaetana Del Vecchio

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Dominic Del Vecchio
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): July 13 1880

8. AGE: Years	Months	Days	If less than one day
65	4	26	..... hrs. ..... min.

8. Birthplace: Italy
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: own home

FATHER
12. Name: Frank Freni
13. Birthplace: Italy

MOTHER
14. Maiden name: unknown
15. Birthplace: Italy

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Lincoln Cemetery
Location: Washington, D.C.
18. Funeral director: L. H. Bevins Co.
Address: 14th St. Washington D.C. N.W.
19. Dec 10 1945 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1945 at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1945, to Dec. 9 1945 and that I last saw her alive on Dec 9 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	27 hrs.
Due to	
Due to	
Other conditions: Psychosis with Cereb. Art.	

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Tibert M.D.
M. D. or other
Address: L.L. Hosp. Sykesville Md. Date signed: 12-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 12167

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1743 Abbottston Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John Henry Dietz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Katherine Dietz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 24, 1868

8. AGE: Years	Months	Days	If less than one day
76	11	23	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Gardner
11. Industry or business:

FATHER
12. Name: Unknown Henry Dietz
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown Caroline Rinehart
15. Birthplace: Unknown

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 20, 1945 (month) (day) (year)
Cemetery or crematory: Maryland Memorial Park
Location: Balto. Md.
18. Funeral director: Samuel J. Rinehart
Address: 5305 Harford Road.
19. Dec 17 1945 (Date rec'd by registrar) C. Henry Steel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17 1945 at 2:10A P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8 1945 to December 17 1945 and that I last saw him alive on December 17 1945

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to: Generalized arteriosclerosis	?
Due to:	
Other conditions: Called to right arm	2 days
Psychosis & Cerebral Arteriosclerosis	2 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold V. Eilert M.D.
M. D. or other
Address: S.S. Hosp., Sykesville, Md. Date signed 12-17-45

12108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-d

CERTIFICATE OF DEATH

Reg. Dist. No. 7483

1. PLACE OF DEATH:
County: Carroll
City or town: New Freedom (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Mt. Freedom - R 4 D 2 (If ontside city or town limits, write RURAL and give nearest town)
Street No.: Lyksesville P.O. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME David Augustus Dorsey — **3.(b) Social Security Number** #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

B.(b) Name of husband or wife: Edith Anthony
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 5, 1870

8. AGE:

Years	Months	Days	If less than one day
75	9	23	hrs. min.

9. Birthplace: Carroll Co., Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: William Dorsey
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary A. Featherwood
15. Birthplace: Md.
16. Informant: Mr. Roland Dorsey
Address: Laurel, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31, 1945 (month) (day) (year)
Cemetery or crematory: Brandenburg Cemetery
Location: Burnt, Carroll Co., Md.
18. Funeral director: C. Harry Wenn
Address: Lykesville, Md.
19. Dec 31 1945 (Date rec'd by registrar) C. Harry Wenn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1945 at 6:40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26, 1945 to Dec. 28 1945
and that I last saw him alive on Dec. 28 1945

Immediate cause of death	DURATION
Hemiplegia - (Left)	3 da
Due to: Advanced Arterio-Sclerosis	? yrs
Due to: and Hypertension	? yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill - M.D. (M. D. or other)
Address: Mt Airy, Md. Date signed 12/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

12109

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Springfield Ave

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Springfield Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carrie May Duvall

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1883

8. AGE: Years 62 | Months - | Days - | If less than one day ..... hrs. ..... min.

9. Birthplace Woodbine Carroll Co. Md.
(Town, county, and state)

10. Usual occupation home-keeper

11. Industry or business

FATHER 12. Name George Duvall

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Ida Hatfield

15. Birthplace Carroll Co. Md.

16. Informant Mrs. Stle Crawford

Address Westminster, Md. R.D.6

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/7/45 (month) (day) (year)

Cemetery or crematory Mowbray Chapel

Location Woodbine Md.

18. Funeral director C. M. Walt

Address R.D.6 Westminster Md.

19. Dec 6 1945 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1945 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945, to Dec 4 1945

and that I last saw h... alive on Dec 3 1945

Immediate cause of death	DURATION
Cardio Vascular	
Due to Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Barnes M.D.
M. D. or other

Address Sykesville Md. Date signed 12/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12110 76

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll Co.
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route #7.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clara E. Eccard.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow.

6.(b) Name of husband or wife: John P. Eccard.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): January 30th 1875

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: maryland (Town, county, and state)
10. Usual occupation: Housework.
11. Industry or business
FATHER 12. Name: Calvin Maine.
FATHER 13. Birthplace: maryland.
MOTHER 14. Maiden name: Sarah
MOTHER 15. Birthplace: maryland.
16. Informant: Roy Eccard
Address: 3538 Buena Vista Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 30, 1945 (month) (day) (year)
Cemetery or crematory: Pleasant Hill
Location: Frederick Co, Md
16. Funeral director: Chenoweth & Donovan
Address: 3615-17 Chestnut Ave.
19. 12/29 19 45 (Date rec'd by registrar) A. W. Hedrick Registrar D.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27, 1945, at 11:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23 1945, to December 27th 1945
and that I last saw h.. alive on December 27th 1945

Immediate cause of death	DURATION
Bronchopneumonia	4 days.
Due to: Influenza	7 days.
Due to:	
Other conditions: Chr. Myocarditis	10 years

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. Chester Bon MD. M. D. or other
Address: Westminster Maryland Date signed: 12/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12111

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Melrose, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Carroll
City or town: Melrose
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William J. Eisenhuth

3.(b) Social Security Number: 220-10-5859

4. Sex	5. Color or Race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella L. Eisenhuth
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): June 6 - 1880

8. AGE: Years	Months	Days	If less than one day
65	6	22	....hrs. ....min.

9. Birthplace: Carroll Co Maryland (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business: State Road
FATHER 12. Name: Andrew Eisenhuth
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Margaret Bowerman
MOTHER 15. Birthplace: Unknown
18. Informant: Ella L. Eisenhuth
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-31-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Earl Wirtz Sons
Address: Manchester Md
19. Dec. 29 1945 Mrs. W. P. S. Dennis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28, 1945, at 5 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2, 1945, to Dec. 28, 1945 and that I last saw him alive on Dec. 17, 1945
Immediate cause of death: Carcinomatosis Stomach Leukemia — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jos. E. Bush M D
M. D. or other
Address: Hampstead Md Date signed: 12/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12112

CERTIFICATE OF DEATH

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Near Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: near Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. Mt Airy

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: HILDA L. FRANKLIN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: William J. Franklin

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1877

8. AGE:

Years	Months	Days	If less than one day
68	2	30	...hrs. ...min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Isaac Kiler

13. Birthplace: Maryland

MOTHER

14. Maiden name: Elizabeth Hooper

15. Birthplace: Maryland

16. Informant: Mr. William J. Franklin

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 12-3-45 (month) (day) (year)

Cemetery ~~or crematory~~: Taylorsville

Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. Dec. 2 1945 (Date rec'd by registrar) E. M. Fraser Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/1 1945, at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 2 1945 to December 1 1945 and that I last saw h... alive on November 30 1945

Immediate cause of death	DURATION
Acute Lobar Pneumonia	3 days
Due to: Cirrhosis of liver	1 year
Other conditions: Hypertension	5 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] (M.D.) M. D. or other

Address: Westminster Md. Date signed 12/3/45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12114

74

Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 2 mos., 15 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2532½ Druid Hill Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: THOMAS CHESLEY GRAY

3.(b) Social Security Number: 155-01-6431

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25, 1911

8. AGE: Years	Months	Days	If less than one day
34	6	25	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Musician
11. Industry or business

FATHER
12. Name: James Gray
13. Birthplace: Calvert County, Md.

MOTHER
14. Maiden name: Annie Gantt
15. Birthplace: Calvert County, Md.

18. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial, Cremation, or removal. Which?: Burial Date thereof: 12/24/45 (month) (day) (year)
Cemetery or crematory: Mutual
Location: Mutual Cemetery Co. Inc.
18. Funeral director: Mr. Samuel D. Hemsley
Address: 578 W. Biddle Street Baltimore
19. (Date rec'd by registrar): Dec. 20, 1945
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20, 1945 at 9:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5, 1942 to Dec. 20, 1945 and that I last saw him alive on Dec. 20, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 12-20-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

12115

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Oakland Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

Sykesville P.O.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Oakland Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sykesville P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Green

3.(b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife: Harry Green

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): July 17, 1885

8. AGE:

Years	Months	Days	If less than one day
60	4	18	....hrs. ....min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER

12. Name: John Goodgesmith

13. Birthplace: Md.

MOTHER

14. Maiden name: Mary Lakiek

15. Birthplace: Md.

16. Informant: Mr. Harry Green

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1945 (month) (day) (year)

Cemetery or crematory: Oakland Methodist Cem.

Location: Mr. Oakland Mills, Carroll Co., Md.

18. Funeral director: C. Harry Wiser

Address: Sykesville, Md.

19. Dec. 7 1945 (Date rec'd by registrar) C. Harry Wiser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 5 1945, at 4-15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1945, to Dec 5 1945

and that I last saw h.. alive on Dec 4 1945

Immediate cause of death	DURATION
Acute Uremia	
Due to: Chronic Int Nephritis	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnency within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. H. Barnes M.D. M. D. or other

Address: Sykesville Md. Date signed: Dec 5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12113

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15a)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 82

1. PLACE OF DEATH:

County Carroll Co

City or town Mt Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo 20 Days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Carroll

City or town Mt Airy Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Erbin Grimes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1945

8. AGE:

Years	Months	Days	If less than one day
	5-	20	hrs. min.

9. Birthplace Mt Airy Md (Town, County, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Roy W. Grimes

FATHER 13. Birthplace Taylorsville Carroll Co

MOTHER 14. Maiden name Cora A. Harrison

MOTHER 15. Birthplace Glenelg Howard Co

16. Informant Mrs Cora A. Grimes

Address Mt Airy

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/8/45 (month) (day) (year)

Cemetery or crematory Mt Olivet

Location Near Mt Airy

18. Funeral director C. M. Waltz

Address Winfield Md

19. Dec. 8 1945 Thos D Snyder

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1945, at 2 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1945, to Dec 7 1945

and that I last saw him alive on Dec 7 1945

Immediate cause of death	DURATION
Congenital Hydrocephalus	
Cause Unknown	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C M Van Foade M. D. or other

Address Mt Airy Date signed Dec 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12116

CERTIFICATE OF DEATH

Reg. Dist. No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William M Harris

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Mary J Blizzard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 5 — 1853

8. AGE: Years	Months	Days	If less than one day
92	2	23	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Ret Farmer
11. Industry or business
12. FATHER — Name: Melchior Harris
13. FATHER — Birthplace: Md
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace: Unknown
16. Informant: James Harris
Address: Hampstead, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-30-45 (month) (day) (year)
Cemetery or crematory: Wesley
Location: Carroll Co Md
18. Funeral director: Edw C Tipton
Address: Hampstead Md
19. Dec 29 1945 (Date rec'd by registrar) John S. Hughes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28 1945 at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 1945 to Dec 28 1945 and that I last saw h... alive on Dec 27 1945

Immediate cause of death	DURATION
Broncho-Pneumonia	8 days
Due to: Grippe	7 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Maurice C. Cartzendafner M. D. or other
Address: Hampstead Md Date signed 12-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12117

Reg. Diat. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Edward T Houck.

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of ~~husband~~ or wife Addie M Stansbury
6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Feb 4 1859

8. AGE: Years	Months	Days	If less than one day
86	10	21	hrs. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Ret farmer
11. Industry or business

FATHER
12. Name Henry Houck
13. Birthplace Md

MOTHER
14. Maiden name Amanda Leppy
15. Birthplace Md

16. Informant Mrs Russell Williams
Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 28 45 (month) (day) (year)
Cemetery or crematory Hampstead
Location Hampstead Md
18. Funeral director Edw Crapton
Address Hampstead Md

19. Dec 27 1945 John S. Hughes Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25, 1945, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1945, to Dec 25 1945 and that I last saw h[illegible] alive on Dec 23, 1945

Immediate cause of death	DURATION
(a) Chronic Hypertension	
Due to	
Due to Coronary Occlusion	Sudden
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jos. E. Burke M.D.
M. D. or other
Address Hampstead Md Date signed 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 12118 76

1. PLACE OF DEATH:
County: Carroll
City or town: rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Samuel Andrew Jackson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Hester K. Rutter
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 24, 1855

8. AGE: Years	Months	Days	If less than one day
90	4	29	hrs. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business

FATHER
12. Name: Samuel A. Jackson
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Margaret Bower
15. Birthplace: Pennsylvania

16. Informant: Frederick R. Jackson
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12/28/45 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 12/26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 19 45, at 6 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44, to Dec - 23 19 45
and that I last saw h.. alive on Dec - 23 - 19 45

Immediate cause of death	DURATION
Myocarditis (chr.)	
Nephritis (chr.)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Jennellend M. D. or other
Address: Westminster Md. Date signed 12-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12119

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos., 17 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium(Colored)
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL und give nearest town)
Street No. 1526 E. Pratt Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eddie Jones

3.(b) Social Security Number: 167-18-2656

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widower

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1902

8. AGE: Years	Months	Days	If less than one day
43	11	7	hrs. min.

9. Birthplace Portsmouth, Va. (Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business

FATHER 12. Name Amos Jones
13. Birthplace Virginia

MOTHER 14. Maiden name Cora Grimes
15. Birthplace New York

16. Informant Reuben Hoffman, M.D.
Address Henryton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-28-45 (month) (day) (year)
Cemetery or crematory University of Maryland
Location Anatomical Laboratory, Balto.

18. Funeral director Mrs. Samuel L. Lemsley
Address 578 W. Biddle St, Balto, Md.

19. 12-26 19 45 (Date rec'd by registrar) Albert R. Snowden deputy local Registrar

MEDICAL CERTIFICATION

a

20. DATE OF DEATH December 26 1945 at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1945 to Dec. 26 1945 and that I last saw him alive on Dec. 26 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	Feb. '45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Md. Date signed 12-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12120

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 4 mos

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr 4 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wash. Co.

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 516 George Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary E. Kershner

3. (b) Social Security Number: none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	divorced

6.(b) Name of husband or wife: -

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Feb 17th - 1861

8. AGE:

Years	Months	Days	If less than one day
84	9	29	... hrs. ... min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business: At home

FATHER

12. Name: Martin Kershner

13. Birthplace: Md.

MOTHER

14. Maiden name: Susan Miller

15. Birthplace: Md.

16. Informant: J. E. Scott

Address: 516 George St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 19, 1945 (month) (day) (year)

Cemetery or crematory: Reform cemetery.

Location: Salem, Maryland

18. Funeral director: Fred W. Krantz

Address: Hagerstown, Maryland.

19. Dec 16 1945 (Date rec'd by registrar) C. Hasty Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16th 1945, at 2-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4th 1944, to Dec 16th 1945 and that I last saw ... alive on Dec 16th 1945

	DURATION
Immediate cause of death	
Chronic Hypertension	?
Due to	
Mitral regurgitation	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 12-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

File # 12121

Reg. Dist. No. 75

1. PLACE OF DEATH:

County Carroll

City or town Manchester Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Carroll

City or town Manchester

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida K. Kneller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward H. Kneller

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Jan. 25, 1867

8. AGE: Years: 78 | Months: 10 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Manchester Md. (Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business

FATHER — 12. Name: John J. Lynard

FATHER — 13. Birthplace: Penn'a.

MOTHER — 14. Maiden name: Elizabeth Frankfater

MOTHER — 15. Birthplace: Maryland

16. Informant: Edward H. Kneller

Address: Manchester Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-27-45 (month) (day) (year)

Cemetery or crematory: cemetery U.B.

Location: Manchester Md

18. Funeral director: Jacob Shanks Sons

Address: Manchester Md.

19. Dec. 26 1945 (Date rec'd by registrar) Mrs. H. R. S. Denver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 1945 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16, 1945, to Dec. 23, 1945 and that I last saw h[illegible] alive on Dec 23 1945

Immediate cause of death	DURATION
(a) Cerebral Hemorrhage	Instant
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Jas. E. Bush M. D. M. D. or other

Address Hanover Md. Date signed 12/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

12122 81

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: William Elmer Kolb

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennie Elizabeth Kolb

6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.): August 8 - 1863

8. AGE: Years	Months	Days	If less than one day
82	4	11	..... hrs. ..... min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Retired

FATHER — 12. Name: Joseph Kolb

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Annie E. Derr

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Charles E. Gray

Address: Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 22-1945 (month) (day) (year)

Cemetery or crematory: Pike Creek Cemetery

Location: Uniontown Road

18. Funeral director: D. H. Hartzler and Sons

Address: Union Bridge and New Windsor, Md.

19. Dec. 21 1945 (Date rec'd by registrar) Richman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 1945 at 10:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 45 to December 19 1945

and that I last saw him alive on December 18 1945

Immediate cause of death: Carcinoma of Larynx — DURATION: ..... yr —

Due to: Generalized Arteriosclerosis — DURATION: yr —

Due to: — DURATION: .....

Other conditions: — DURATION: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Jno. F. Shaum M. D. or other

Address: Westminster Md Date signed 12-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

12122

Reg. Diat. No. 548

1. PLACE OF DEATH:
County: Carroll County
City or town: Sykesville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 days
Hospital, Institution, or street address where death occurred: Springfield State Hosp.
How long in hospital or institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 167 Baltimore Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Paul Lannon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Febr. 11 1904

8. AGE: Years	Months	Days	If less than one day
36	10	14	hrs. min.

9. Birthplace: Barton Md.
(Town, county, and state)
10. Usual occupation: barber
11. Industry or business

FATHER
12. Name: unknown
13. Birthplace

MOTHER
14. Maiden name: unknown
15. Birthplace

16. Informant: Ann Lannon wife
Address: 167 Baltimore St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 28 1945 (month) (day) (year)
Cemetery or crematory: Cumberland
Location: Cumberland Md.
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Dec 25 1945 (Date rec'd by registrar) C. Harry Lloyd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1945, at 1.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Dec. 24 1945 and that I last saw him alive on Dec. 24 1945

	DURATION
Immediate cause of death: uraemia	3 days
Due to: Chronic nephritis	years
Due to:	
Other conditions: Arthritis Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Kamm M. D. or other
Address: Springfield State Hosp. Date signed 12-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12124

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 1627 Miller Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ESTELLE LEARY

3.(b) Social Security Number: 212-12-5941

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7, 1919

8. AGE: Years	Months	Days	If less than one day
26	8	7	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Nelson Leary
13. Birthplace: Eddington, N.C.

MOTHER
14. Maiden name: Annita Gainbry
15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12-17-45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A. A. County.
18. Funeral director: Elroy O. Wilson
Address: 1003 Brantly ave

19. Dec. 14, 1945 (Date rec'd by registrar) Albert R. Swanhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14, 1945, at 12:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23, 1945 to Dec. 14, 1945 and that I last saw her alive on December 14, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	?
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 12-14-45

(M) MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

12125

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
M. P. Church Home for the Aged
How long in hospital or Institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main & Church Sts.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Philip M. Lemmon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Eva B. Devilbiss
6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): April 7, 1861

8. AGE: Years	Months	Days	If less than one day
84	8	4	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)
10. Usual occupation: labor
11. Industry or business:

FATHER
12. Name: Not known
13. Birthplace: " "

MOTHER
14. Maiden name: " "
15. Birthplace: " "

18. Informant: Mrs. Philip M. Lemmon
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12/13/45 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Woodlawn, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 12/11/45 (Date rec'd by registrar) 19 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December ~~10~~ 11th 1945, at 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/7/45 to 12/11/45
and that I last saw h— alive on 12/10 19

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: General Arterio — Sclerosis	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or Other
Address: Westminster Date signed: 12/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12126

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 17 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 6 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3416 Lindale Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: George W. Leon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennifer Leon
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 15, 1894 20 days

8. AGE: Years	Months	Days	If less than one day
51	10	20	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business: ----

FATHER
12. Name: Joseph Leon
13. Birthplace: Maryland

MOTHER
14. Maiden name: Marguerite Mahon
15. Birthplace: Maryland

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 8, 1945 (month) (day) (year)
Cemetery or crematory: London Park Cem.
Location: Balto., Md.
18. Funeral director: Williams Cook, Inc.
Address: 1217 St. Paul St.

19. Dec 5 1945 (Date rec'd by registrar) C. Henry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1945, at 9:40a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 18 1945, to December 5 1945
and that I last saw him alive on December 5 1945

Immediate cause of death	DURATION
General Paralysis of the Insane	1 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other
Address: S.H.Hosp. Sykesville, Md. Date signed 12-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

12127

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
Methodist Home for the Aged
How long in hospital or institution? 25 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main & Church Sts.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Kate L. Lockard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Joshua Lockard
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 9, 1855

8. AGE: Years: 90 | Months: 6 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Montrose, Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: John Lloyd
13. Birthplace: Maryland

MOTHER
14. Maiden name: Helen Stocksdale
15. Birthplace: Maryland

16. Informant: Mrs. George Mather
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12/14/45 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 12/12 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 19 45, at 5 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 19 45 to Dec. 12 19 45 and that I last saw h alive on Dec. 5 19 45

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to: Cardiac Infarcts & Arteriosclerosis	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or Coroner
Address: Westminster Date signed: 12/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12128

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 1 day
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 1 yr 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegheny
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emma Gertrude Lehrman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 2, 1889

8. AGE: Years	Months	Days	If less than one day
56	7	9	hrs. ..... min.

9. Birthplace: Cumberland. (Town, county, and state)
10. Usual occupation: presser
11. Industry or business: tailor shop.
12. FATHER — Name: Alfonsus Lehrman
13. FATHER — Birthplace: Cumberland
14. MOTHER — Maiden name: Margaret Hoffman
15. MOTHER — Birthplace: Cumberland.
16. Informant: Fredrick G. Lehrman
Address: 319 Everett Ave Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 14, 1945 (month) (day) (year)
Cemetery or crematory: St Peter and Paul's
Location: Cumberland Md.
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md
19. 12/14/45 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11th 1945, at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9th 1945, to Dec 11th 1945
and that I last saw her alive on Dec 11th 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	2
Due to: Tuberculous pleurisy with effusion	?
Due to: Chronic fibrous pulmonary tuberculosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: J. J. Gaston M.D. M. D. or other
Address: Sykesville Md. Date signed 12/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

CERTIFICATE OF DEATH

12129

Reg. Dist. No. 24

1. PLACE OF DEATH:

County CARROLL

City or town RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yr., 11 mo., 1 day

Hospital, institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 24 yr., 11 mo., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 232 Arch Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles F. Lynch

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	married

6.(b) Name of husband or wife Laura

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) ____ 1867

8. AGE: Years	Months	Days	If less than one day
78	?	?	____ hrs. ____ min.

9. Birthplace W. Virginia
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business railroad

FATHER 12. Name York

13. Birthplace

MOTHER 14. Maiden name York

15. Birthplace

16. Informant SPRINGFIELD STATE HOSPITAL RECORDS

Address SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal Which?) Date thereof Dec. 10, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director Hafer Funeral Home

Address Cumberland, Md.

19. Dec. 6 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1945, at 3:30p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to December 6 1945

and that I last saw h IM alive on December 6 1945

Immediate cause of death	DURATION
Fracture of left hip due to fall in public institution	3 days
Due to	
Due to	
Other conditions Psychosis with cerebral arteriosclerosis	25 years

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-3-45

Where did injury occur? Sykesville, Carroll, Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) institution

Means of injury fall Injured at work? no

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE Robert Bertrand May, M.D.
M. D. or other

SPRINGFIELD STATE HOSPITAL

Address SYKESVILLE, MARYLAND Date signed 12-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12130

Reg. Dist. No. 77

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Clinton R Mahanna

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 30 - 1897

8. AGE:

Years	Months	Days	If less than one day
47	11	24	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Charles E Mahanna
13. Birthplace: Md

MOTHER
14. Maiden name: Ella Ward
15. Birthplace: Md

16. Informant: Chas A Mahanna
Address: R.D. #7, Westminster Md

17. Burial (Burial, cremation, or removal—which?) Date thereof 12-28-45 (month) (day) (year)

Cemetery or crematory: Emory

Location: Carroll Co Md

18. Funeral director: Edw C Tipton

Address: Manchester Md

19. Dec. 27 1945 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24, 1945 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Dec. 23, 1945 to Dec 24, 1945 and that I last saw h... alive on Dec 23, 1945

Immediate cause of death	DURATION
Double Pneumonia	
Bronchial Pneumonia	2 da
Due to	
Due to Bronchial cancer Unknown	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jas E. Burke M.D.
M. D. or other

Address: Manchester Md Date signed 12/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12131

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos. 18 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 mos. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3720 Falls Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
Hazel Curtis Martin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Robert Daniel Martin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1921

8. AGE: Years	Months	Days	If less than one day
24	0	16	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jesse S. Curtis
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ada Peterson
15. Birthplace: Maryland

16. Informant: Records of Springfield State
Address: Hosp., Sykesville, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Dec. 16, 1945 (month) (day) (year)
Cemetery or crematory: Poplar Church Cemetery
Location: Warren, Balto. Co. Md.

16. Funeral director: William Cook Jr.
Address: 1217 St Paul St.

19. Dec 8 1945 C. Harry Edw
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1945 at 7:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1945, to December 8 1945
and that I last saw her alive on December 8 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mos.
Due to:	
Due to:	
Other conditions Epilepsy without Psychosis; Mental Deficiency	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other
Address: S.S. Hosp. Sykesville Md. Date signed: 12-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12132

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William David Martin

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Edna Belle Frank
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) July 2 1882

8. AGE: Years	Months	Days	If less than one day
63	4	26	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name David Martin
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Virginia Morelock
15. Birthplace Carroll Co. Md.
16. Informant William F. Martin
Address Westminster Md. Ft 4
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 7 1945 (month) (day) (year)
Cemetery or crematory Rridere
Location Westminster Md.
18. Funeral director H Bankard & Son
Address Westminster Md.
19. 12/6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4th 1945, at 9.40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25. 1945, to Dec 4th 1945
and that I last saw him alive on Dec 3 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 days
Due to Chronic Interstitial Nephritis	2 yrs
Due to Arterio Sclerosis	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas R Fenby M.D.
M. D. or other
Address Westminster Md. Date signed 12-5-45

12133

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 18 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: California
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOSEPH BERNARD MATTHEWS

3.(b) Social Security Number: 200-10-1308

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Unk -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3, 1908

8. AGE:	Years	Months	Days	If less than one day
	37	6	15	hrs. min.

9. Birthplace: California, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Alvin Matthews
13. Birthplace: St. Mary's County, Md.

MOTHER
14. Maiden name: Ella Dawson
15. Birthplace: California, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-21-45 (month) (day) (year)
Cemetery or crematory: Holy Face
Location: Great Mills, Md
18. Funeral director: W.C. Mattingley Sons
Address: Leonardtown, Md.

19. Dec. 18, 1945 (Date rec'd by registrar) Albert R. Swann Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18, 1945 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31, 1945 to Dec. 18, 1945 and that I last saw him alive on Dec. 18, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1, 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed 12-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

12134

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos. 18 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 5 mos. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1562 North Fulton Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Rose Matz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Louis Matz

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1898

8. AGE:	Years	Months	Days	If less than one day
	47	11	?	hrs. min.

9. Birthplace: Boston, Mass. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Max Shear

13. Birthplace: Russia

MOTHER — 14. Maiden name: Dora

15. Birthplace: Russia

16. Informant: Records of Springfield State Hospital, Sykesville, Md.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24-45 (month) (day) (year)

Cemetery or crematory: Rosedale

Location: Hamilton Ave

18. Funeral director: Jack Lewis Inc

Address: 2100 Eutaw Place

19. Dec. 22 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1945, at 1:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1945 to December 22 1945 and that I last saw h[illegible] alive on December 22 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Unknown
Due to:	
Due to:	
Other conditions: Schizophrenia, Paranoid type (Include pregnancy within 3 months of death)	5 years

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: S. Main St, Sykesville, Md. Date signed: 12-22-45

12135

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 80

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Fannie A. Nicodemus

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband ~~or wife~~: late Charles Nicodemus
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3 - 1864

8. AGE: Years: 81 | Months: 6 | Days: 22 | If less than one day: hrs. min.

9. Birthplace: Frederick County, Md.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER
12. Name: Thomas Eigenbell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anne M. Poole
15. Birthplace: Maryland

16. Informant: Mrs. Margaret Pearre
Address: New Windsor, Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Dec. 28 - 1945 (month) (day) (year)
Cemetery or crematory: Sunnyside Cemetery
Location: Westminster, Md

18. Funeral director: H. W. Gaither & Sons
Address: Union Bridge & New Windsor, Md

19. Dec 27 1945 (Date rec'd by registrar) Ernest Bendel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1945, at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 25 1945 and that I last saw h~~er~~ alive on Dec 24 1945

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to: Cerebral Hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Brdg. Date signed: 12-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-2)

CERTIFICATE OF DEATH

12136

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: near East View
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: near East View
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Laban Garfield Ogg

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nellie M. Miner
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): October 18, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	26	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)
10. Usual occupation: farmer
11. Industry or business

FATHER
12. Name: George W. Ogg
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura F. Williams
15. Birthplace: Maryland

16. Informant: Mrs. Laban G. Ogg
Address: Westminster, Md. R.D.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12/17/45 (month) (day) (year)
Cemetery or crematory: Deer Park Cemetery
Location: Smallwood, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 12/15 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1945, at 11p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-30- 1944, to 12-14- 1945 and that I last saw him alive on 12-14 1945

Immediate cause of death	DURATION
Cardiac Decompensation	1½ yrs
Portal Cirrosis	1½ yrs
Due to Chr. Nephritis	1½ yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. D. Eagles M.D. (M. D. or other)
Address: Reisterstown, Md. Date signed: 12-15-45

12137

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr., 7 mo., 15 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 yr., 7 mo., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John O'Halleran

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	unknown

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) ~~1880~~ (?) 1875?

8. AGE: Years: appears to be 70 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER — 12. Name: Patrick O'Halleran
13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary O'Leary
15. Birthplace: Ireland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial, (Burial, cremation, or removal. Which?) Date thereof Dec. 17 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cemetery
Location: Sykesville, Md.

18. Funeral director: C. Harry Wm
Address: Sykesville, Md.

19. Dec. 17 1945 (Data rec'd by registrar) C. Harry Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1945 at 4:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13 1943, to Dec. 14 1945 and that I last saw him alive on December 13 1945

Immediate cause of death	DURATION
Arteriosclerosis	4 years
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	4 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 12-14-45

VS A15

RELEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12138

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1031 N. Portland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROSA PERVIS

3.(b) Social Security Number: 217-01-5936

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 15, 1903

8. AGE: Years	Months	Days	If less than one day
42	2	18	hrs. min.

9. Birthplace: Rocky Mountain, N.C. (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business

FATHER
12. Name: Andrew May
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Martha Scarborough
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: annapolis Rd.
16. Funeral director: Mrs Robert Elliott & daughter
Address: 1129 N. Caroline St.

19. Dec. 3, 1945 (Date rec'd by registrar) Albert R. Swanston Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3, 1945, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3, 1945, to Dec. 3, 1945 and that I last saw her alive on December 3, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1, 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Maryland Date signed 12-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12139

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Garrison, Maryland
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George R. Rittinger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 2, 1927

8. AGE: Years	Months	Days	If less than one day
18	4	29	..... hrs. ..... min.

9. Birthplace: Garrison, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Charles Pittinger
13. Birthplace: Garrison, Maryland

MOTHER
14. Maiden name: Mabel B. Younger
15. Birthplace: Baltimore, Maryland

16. Informant: Mabel Younger Haines
Address: Baltimore, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/46 (month) (day) (year)
Cemetery or crematory: St. Charles
Location: Pikesville, Md

18. Funeral director: Frank H. Mercer
Address: Pikesville, Md.

19. 12/31/45 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 1945 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23 1945 to December 31 1945 and that I last saw him alive on December 31 1945

Immediate cause of death	DURATION
Atypical pneumonia	5 days
Due to: Flu	7 days
Due to:	
Other conditions: Psychosis	10 days.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. R. Rittinger M. D. or other
Address: Springfield State Hosp. Date signed 12-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

12140

CERTIFICATE OF DEATH

★ Reg. Dist. No. 87

1. PLACE OF DEATH:

County: Carroll

City or town: Rural--Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural---Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: OLIVER D. RIDGELY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ida M. Ridgely

Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 23, 1850

8. AGE:

Years	Months	Days	If less than one day
95	3	2	..... hrs. ..... min.

9. Birthplace: Howard Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer (retired)

11. Industry or business

FATHER — 12. Name: Henry K. Ridgely

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Achah Dorsey

15. Birthplace: Maryland

16. Informant: Mr. Charles W. Ridgely

Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-28-45 (month) (day) (year)

Cemetery or crematory: Mt. Olive

Location: Mt. Olive, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19 Dec. 27 19 45 Thos D Snyder

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25, 19 45 at 10;45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
General Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James T. Shand Deputy Medical Examiner M. D. or other

Address: Westminster Md. Date signed 12-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

CERTIFICATE OF DEATH

1214176

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 109 W. Main St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 109 W. Main St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Maggie L. Robertson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: James J. Robertson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 21 - 1869

8. AGE:

Years	Months	Days	If less than one day
76	7	26	..... hrs. ..... min.

9. Birthplace: Carroll County, Md

(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER — 12. Name: Pius Babylon

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Missouri Burchart

MOTHER — 15. Birthplace: Maryland

16. Informant: Margaret Robertson

Address: 109 W. Main St. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19-1945 (month) (day) (year)

Cemetery or crematory: Baust Lutheran Church

Location: Jewettown Road

18. Funeral director: D. O. Hartsuk & Sons

Address: Union Bridge & New Windsor Md

19. 12/18 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 17, 1945, at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 15 1945 to Dec 17 1945 and that I last saw h[illegible] alive on Dec. 16 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to: Cerebral Hemorrhage	2 days
Due to: arteriosclerosis	57 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lehas R Pontius M. D. or other

Address: Westminster Md Date signed 12-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

12142

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yr., 9 mo., 27 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 37 yr., 9 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unk -
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Rogg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1877

8. AGE: Years	Months	Days	If less than one day
68 (?)	?	?	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business
FATHER 12. Name: Unk -
FATHER 13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Unk -
MOTHER 15. Birthplace: Maryland
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18, 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Wees
Address: Sykesville, Md.
19. Dec. 18 1945 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17 1945 at 7:20p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to Dec. 17 1945 and that I last saw him alive on December 17 1945

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	2 yrs.
Due to:	
Due to:	
Other conditions: Psychosis with mental deficiency	40 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 12-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

12143

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred:

146 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 146 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Josie Myers Russell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widowed

6.(b) Name of husband or wife Frank J. Russell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 26, 1871

8. AGE: Years	Months	Days	If less than one day
74	7	18	..... hrs. ..... min.

9. Birthplace Fred Co. Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John W. Myers

13. Birthplace Fred Co. Md.

MOTHER 14. Maiden name Alice Sidwell

15. Birthplace Fred Co. Md.

16. Informant Mrs. Sarah N. Bennett

Address 146 W. Main St. Westminster Md

17. Burial Date thereof 12/16/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friends' Cemetery

Location Union Bridge Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. 12/15-45 L. K. Woodward

(Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1945 at 10:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 8 1945 to Dec. 14 1945 and that I last saw h[illegible] alive on Dec. 14 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	1 wk.
Due to General Arterio-Sclerosis.	several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. K. Woodward M. D. or Other

Address Westminster Date signed 12/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

12144

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 4 mos., 22 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium(Colored)
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Sparrow Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 623 I Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter Seay

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1915

8. AGE: Years	Months	Days	If less than one day
30	4	6	hrs. min.

9. Birthplace Sparrows Point, Md. (Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name William Seay
13. Birthplace Unknown

MOTHER
14. Maiden name Susie Johnson
15. Birthplace Appomatox, Va.

16. Informant Reuben Hoffman, M.D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 30 -45 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location A. A. Co Md.
18. Funeral director Sam'l N. Chase Sons
Address 638 N. Gilmor

19. Dec. 26 1945 (Date rec'd by registrar) Albert R. Swadkins Deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1945 at 5:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 4 1943 to Dec. 26 1945 and that I last saw him alive on Dec. 26 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	Jan. 43
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 12-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

12145

Reg. Diat. No. 87

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt Airy.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alice Pearle Sponsella

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Clinton Sponsella

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1881

8. AGE:

Years	Months	Days	If less than one day
64	8	23	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: John Bowie

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Helen Root

MOTHER 15. Birthplace: Virginia

16. Informant: Mrs. Harold Johnson

Address: Mt. Airy, Md

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 12-26-45 (month) (day) (year)

Cemetery or crematory: Pine Grove

Location: Mt Airy, Carroll Co. Md

18. Funeral director: C. M. Wallis

Address: Winfield, Md

19. Dec. 26 1945 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24, 1945, at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to Dec 24 1945 and that I last saw h.. alive on December 24 1945

	DURATION
Immediate cause of death: Cardiac Decompensation	2 mo
as a Chr. Uremia	2 wks
Due to Chr. Myocarditis	? yrs
and Chr. Interstitial Nephritis	? yrs
Due to:	
Other conditions: Chr. Hypertension	? yrs
Arterio-Sclerosis	? yrs

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other

Address: Mt Airy, Md Date signed 12/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12146

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll Co

City or town: Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months + 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: near Sidwicks mill

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Elizabeth Reichel Sprowl

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	W.	widowed

6.(b) Name of husband or wife: Fred Sprowl

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 28 1870

8. AGE: Years	Months	Days	If less than one day
75	11	2	____ hrs. ____ min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: ? Reichel

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. Orwell W. Doss

Address: Westminster RD 3 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3, 46 (month) (day) (year)

Cemetery or crematory: Meadow Branch

Location: near Westminster Md.

18. Funeral director: J. E. Myers Jr.

Address: Westminster Md.

19. 1/2 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 31 1945, at 11.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945 to Dec 31, 1945 and that I last saw her alive on Dec 31, 1945

Immediate cause of death	DURATION
Myocardial degeneration	6 mos.
Due to: arteriosclerosis	duedefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: E Reese Wilkens M. D. or other

Address: Westminster Md. Date signed: 12/31/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 4 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2431 Madison Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BEATRICE STEWART

3.(b) Social Security Number: 217-20-4775

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Paul Stewart
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): January 26, 1921

8. AGE: Years	Months	Days	If less than one day
24	10	6	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Joseph Carter
13. Birthplace: Bowie, Maryland

MOTHER
14. Maiden name: Myrtle Short
15. Birthplace: Charles County, Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-7-45 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location:
18. Funeral director: Mc Geo H Holland
Address: 1631 Druid Hill ave

19. Dec. 2, 1945 (Date rec'd by registrar) Albert A Swanborn Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2, 1945, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1945 to Dec. 2, 1945 and that I last saw her alive on Dec. 2, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1, 1945
Due to	
Due to	
Other conditions	

(Includn pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 12-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 24

CERTIFICATE OF DEATH

12148

Reg. Dist. No. 75

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Carroll
City or town Near Manchester (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bessie May Stoffle

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of ~~husband or wife~~: Horatio G. E. Stoffle
6.(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): June 24, 1888
8. AGE: Years 57 | Months 5 | Days 27 | If less than one day ... hrs. ... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business
FATHER 12. Name: Eli F. Yingling
13. Birthplace: Maryland
MOTHER 14. Maiden name: Emma J. Zepp
15. Birthplace: Penna.
16. Informant: Horatio G. E. Stoffle
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Lesters Church
16. Funeral director: Jarol R. T. Wantz
Address: Manchester Md.
19. Dec. 23 1945 Mrs. W. R. S. Demmer (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21 1945 at 1:00 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945 to Dec. 21 1945
and that I last saw h... alive on Dec. 15 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	15 min
Due to: Coronary Arteriosclerosis	5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. C. Carter Fried M. D. or other
Address: Hampstead Md Date signed: 12-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12149

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Samuel Young Stuller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife: Sarah Kemper

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 18 - 1863

8. AGE: Years 82 | Months 11 | Days 13 | If less than one day: hrs. min.

9. Birthplace: Carrol County, Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: John Stuller

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Leah Young

MOTHER — 15. Birthplace: Maryland

18. Informant: Mrs. B. Waddell

Address: New Windsor, Md R. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2-1946 (month) (day) (year)

Cemetery or crematory: Friends Cemetery

Location: Westminster, Md R. D.

18. Funeral director: W. H. Hartley & Sons

Address: Uniontown Bridge & New Windsor, Md

19. Jan 2 1946 (Date rec'd by registrar) Ernest S. Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 1945 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1945 to Dec 31 1945 and that I last saw him alive on December 30 1945

Immediate cause of death	DURATION
Lobar Pneumonia	2 Days
Due to	
Due to	
Other conditions Arteriosclerotic & V disease	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Mead M.D. M. D. or other

Address: Westminster Md Date signed: 12-31-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12150

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 3 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. ------
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George W. Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Not known
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 14, 1901

8. AGE: Years	Months	Days	If less than one day
44	5	4	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Tanner
11. Industry or business -----

FATHER
12. Name Joseph H. Taylor
13. Birthplace Maryland

MOTHER
14. Maiden name Rebecca Barber
15. Birthplace Maryland

16. Informant Springfield State Hospital,
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 23 45 (month) (day) (year)
Cemetery or crematory Cemetery Greenlawn
Location W. Williamsport
18. Funeral director Edel & Fest
Address Williamsport Md
19. Dec-20 1945 C. Henry Wiles
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945 at 11:30 M a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16 1945 to Dec. 19 1945 and that I last saw h im alive on December 19 1945

Immediate cause of death	DURATION
Pneumonia	1 day
Due to Influenza	3 days
Due to	
Other conditions Psychosis, Syphilitic meningo-encephalitis	2½ years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichert, M.D.
M. D. or other
Address S.S. Hosp. Sykesville, Md. Date signed 12-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-0

CERTIFICATE OF DEATH

Reg. Dist. No. 1215176

1. PLACE OF DEATH:
County: Carroll
City or town: rural Patapsco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: rural Patapsco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Laura Jane Taylor

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: David E. Taylor
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 11, 1868

8. AGE: Years	Months	Days	If less than one day
77	2	6	hrs. min.

9. Birthplace: Carrollton, Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: William Blizzard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susanne Wisner
15. Birthplace: Maryland

16. Informant: Mrs. Ada M. Kidd
Address: Patapsco, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12/19/45 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Carrollton, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 12/18/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17 19 45, at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 - 1945, to Dec 17 1945
and that I last saw h... alive on Dec 14 1945

Immediate cause of death	DURATION
Carcinoma intestine	
(a) liver	
Due to: Mayo conditis (b)	
Nephritis (c)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Jamette M.D.
M. D. or other
Address: Westminster Md. Date signed: 12-17-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 84a

12152

CERTIFICATE OF DEATH

Reg. Diat. No. 80

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Nathan Eltz

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27-1908

8. AGE: Years 36 | Months 11 | Days 28 | If less than one day hrs. min.

9. Birthplace Carroll County, Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Daniel S. Eltz
13. Birthplace Maryland

MOTHER
14. Maiden name Annie R. Keefer
15. Birthplace Maryland

16. Informant Daniel S. Eltz
Address New Windsor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 28-1945 (month) (day) (year)
Cemetery or crematory Pipe Creek Cemetery
Location Uniontown Road
18. Funeral director H. H. Hartley & Sons
Address Union Bridge & New Windsor Md

19. Dec 27 1945 (Date rec'd by registrar) Ernest Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1945 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945, to December 25 1945 and that I last saw him alive on December 23 1945

Immediate cause of death	DURATION
Suicide	
Due to Refused to eat - mentally deficient	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T Shaw M. D. or other
Address Westminster Md Date signed 12-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

12153

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 Days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 73 Bond
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Flora Virginia Warehime

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 19 1820

8. AGE:

Years	Months	Days	If less than one day
69	4	21	..... hrs. ..... min.

9. Birthplace Melrose, Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Eli Warehime
13. Birthplace Md.

MOTHER
14. Maiden name Anna Mary Yingling
15. Birthplace Md.

18. Informant Mrs. Norman E. Earhart
Address 73 Bond St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12 - 1945 (month) (day) (year)
Cemetery or crematory Silver Run Cemetery
Location Silver Run, Md.

18. Funeral director H. Bankard Son
Address Westminster Md.

19. 12/10 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10th 1945, at 5a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1-44 19.., Dec. 10. 45
and that I last saw h alive on Dec 8th 19 45

Immediate cause of death	DURATION
Carcinoma Right Breast	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas R Fauth M.D. M. D. or other
Address Westminster Md Date signed 12.10.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12154

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: West Virginia County:

City or town: Kempton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Melvin Watring

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Genevieve Watring

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ~~unknown~~ May 25, 1910

8. AGE: Years 35 | Months 6 | Days 23 | If less than one day: hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER 12. Name: ~~Unknown~~ Raymond Watring

13. Birthplace: Aurora, W. Va.

MOTHER 14. Maiden name: ~~Unknown~~ Ella Huff

15. Birthplace: Preston Co., W. Va.

16. Informant: Records of Springfield State Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24, 1945 (month) (day) (year)

Cemetery or crematory: Aurora

Location: Aurora, W. Va.

18. Funeral director: J. D. D. Duncan

Address: Thomas, W. Va.

19. Dec 22 1945 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17 1945, to December 20 1945

and that I last saw him alive on December 20 1945

Immediate cause of death	DURATION
Syphilitic Aortitis	unknown
Due to:	
Due to:	
Other conditions: Psychosis & syphilitic arteritis, meningo-encephalitis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Sichart M.D. M. D. or other

Address: S.S. Hosp., Sykesville, Md. Date signed: 12-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12155

Reg. Dist. No. 76

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 71 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 Liberty St.
(If rural, give LOCATION)
2.(a) If veteran, name war American

3.(a) FULL NAME Capt. John Nicholas Weigle

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Ruthina Trostle
B.(c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) March 16 1870

8. AGE:	Years	Months	Days	If less than one day
	75	9	14	...hrs. ...min.

9. Birthplace Gettysburg, Pa. (Town, county, and state)
10. Usual occupation U.S.A. Ret. Chief of Police-Wild Commissioner Ret.
11. Industry or business

FATHER
12. Name John Nicholas Weigle
13. Birthplace Gettysburg, Pa.

MOTHER
14. Maiden name Lucinda Snyder
15. Birthplace Gettysburg, Pa.

16. Informant Edgar Weigle
Address 16 E. Main Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 - 1946 (month) (day) (year)
Cemetery or crematory Medar Branch cemetery
Location Westminster, Md.
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. 1/1 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 - 45 at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1932 19... to Dec 30 - 19 45
and that I last saw him alive on Dec 29 - 19 45

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennelle M.D.
M. D. or other
Address Westminster Md. Date signed 12-31-45

12156

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County: Carroll

City or town: Tyrone
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Ida Theresa Weishaar

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: George F. Weishaar

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 25, 1858

8. AGE:	Years	Months	Days	If less than one day
	87	2 (3/4)	2	hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Frederick Englar
13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Carroll Weishaar
Address: Westminster, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 29, 1945 (month) (day) (year)

Cemetery or crematory: Baust

Location: Near Tyrone, Md.

19. Funeral director: C. O. FUSS & SON
Address: Taneytown, Md.

19. Dec. 29, 1945 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27th 1945 at 2 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 24 1945 to Dec 27 1945 and that I last saw her alive on Dec 26th 1945

Immediate cause of death: Arterial Sclerosis — DURATION:

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John J. Stewart M. D. or other

Address: Westminster, Md. Date signed: Dec 29 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

12157 74

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs 2 mos 18 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 28 yrs 2 mos 18 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Maud Whipp

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: David C Whipp

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 15th 1876

8. AGE: Years: 69 | Months: 2 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Md.

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER 12. Name: Benjamin F Kerbs

13. Birthplace: Md

MOTHER 14. Maiden name: Helen M Kerr

15. Birthplace: Md

16. Informant: D Clarence Whipp

Address: 42 W Washington St Hag

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Hagerstown (month) (day) (year) Dec. 22, 1945

Cemetery or crematory: Rose Hill Cem.

Location: Hagerstown, Md.

18. Funeral director: C. K. Coffman

Address: Hagerstown, Md.

19. Dec 20 1945 C. Harry Eby

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1945 at 6.40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2d 1945 to Dec 20 1945

and that I last saw h... alive on Dec 20th 1945

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to: Cerebral Arterio Sclerosis	10 yrs
Due to: Hypertension	6 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville Md Date signed: 12/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12158

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 21 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Mary White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 27, 1906

8. AGE: Years	Months	Days	If less than one day
39	3	24	..... hrs. ..... min.

9. Birthplace Huntington, Long Island
(Town, county, and state)
10. Usual occupation Secretary
11. Industry or business ----

FATHER
12. Name Not known John M. White
13. Birthplace Not known Brooklyn, N.Y.

MOTHER
14. Maiden name ~~Not known~~ Susan Pearson
15. Birthplace ~~Not known~~ Brooklyn, N.Y.

16. Informant Records of Springfield State
Address Hospital, Sykesville, Md.

17. ~~Burial~~ (Burial, cremation, or removal. Which?) Date thereof Dec. 26, 1945 (month) (day) (year)
Cemetery or crematory Greenwood Cemetery
Location New York.
19. Funeral director C. Harry Klee
Address Sykesville, Md.

19. Dec. 22 1945 C. Harry Klee
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 1945 to Dec. 21 1945 and that I last saw her alive on December 21 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	13 years
Due to	
Due to	
Other conditions	
Manic Depressive Psychosis (Include pregnancy within 3 months of death)	2 years

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichert M.D.
M. D. or other
Address S. H. Hosp. Sykesville, Md. Date signed 12-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12159

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

Reg. Diat. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Greenmount
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Greenmount
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William A. White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife: Cora M Cullison
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): March 12 1888

8. AGE: Years: 57 | Months: 9 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Brick-Layer

11. Industry or business

FATHER
12. Name: William H. White
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Porter
15. Birthplace: Maryland

16. Informant: Mrs Wm. A. White
Address: Greenmount Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof 12-20-45 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Carroll Co Md

16. Funeral director: Edwin Tipton
Address: Hampstead Md

19. Dec. 19 19 45 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 16 1945, at 11:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to Dec 16 1945 and that I last saw h~~im~~ alive on Dec. 15 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	1 Year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Stomach Date of op. July 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. C. Partridge M. D. or other
Address: Hampstead Md Date signed: 12-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12160

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yr., 10 mo., 8 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 33 yr., 10 mo., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1148 W. Fayette Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John W. Wilson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	unknown

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years	Months	Days	If less than one day
66	?	?	hrs. min.

9. Birthplace: York — (Town, county, and state)
10. Usual occupation: electrician
11. Industry or business
FATHER 12. Name: York,
13. Birthplace
MOTHER 14. Maiden name: York,
15. Birthplace
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18, 1945 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Wenz
Address: Sykesville, Md.
19. Dec. 18 1945 (Date rec'd by registrar) C. Harry Wenz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 19 45 at 4:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43, to December 16 19 45
and that I last saw him alive on December 16 19 45

	DURATION
Immediate cause of death: Coronary occlusion	instant
Due to:	
Due to:	
Other conditions: Dementia precox	40 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 12-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-a)

12161

CERTIFICATE OF DEATH

Reg. Diat. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 91 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Susanna H Wilson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William H Wilson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 6 - 1854

8. AGE:

Years	Months	Days	If less than one day
91	10	10	hrs. min.

9. Birthplace Carroll Co Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
12. FATHER Name — Baltimore
13. Birthplace Maryland
14. MOTHER Maiden name Not Known
15. Birthplace Not Known
16. Informant Mrs Charles Selby
Address Union Bridge
17. Burial Date thereof Dec 15 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Church of God Cemetery
Location Uniontown Maryland
18. Funeral director D. D. Hartle & Sons
Address Union Bridge & New Windsor Md
19. Dec. 18 1945 M Eichman Deputy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1945, at 2.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1945 to Dec 16 1945 and that I last saw h— alive on Dec 15 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Myerly M.D.
M. D. or other
Address Union Bridge Date signed Dec 17

Evidence for change of year of birth shown on film G99 12/26/45 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

12162

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 9 mos 22 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 9 mos 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 4019 Edmondson Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary J Wode

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 25 - 1877 - 1880

8. AGE: Years 68 | Months 0 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at home

FATHER 12. Name: Charles Wode

FATHER 13. Birthplace: Baltimore

MOTHER 14. Maiden name: Alice Alspach

MOTHER 15. Birthplace: Baltimore

16. Informant: Charles Wode

Address: 4019 Edmondson Ave Balto

17. (a) Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 7-45 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Pikesville Md

18. Funeral director: Wm Cook Inc

Address: 1217 St Paul St

19. Dec 6 1945 (Date rec'd by registrar) C. Henry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 5th 1945 at 8.45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1st 1939 to Dec 5th 1945

and that I last saw h alive on Dec 5th 1945

	DURATION
Immediate cause of death	
Carcinoma of face	2 yrs
Due to	
Epilepsy	60 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W J Gastin MD M. D. or other

Address: Sykesville Md Date signed: 12-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12163

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pennington Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Liggie Yohn

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Yohn Sr.

8. If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 1 1862

8. AGE:

Years	Months	Days	If less than one day
83	11	2	..... hrs. ..... min.

9. Birthplace: Frederick County Maryland
(Town, county, and state)

10. Usual occupation: School Teacher - Housewife

11. Industry or business:

MOTHER

12. Name: Theodore Hoffman

FATHER

13. Birthplace: Maryland

MOTHER

14. Maiden name: Louisa A. Snook

15. Birthplace: Maryland

18. Informant: William Yohn Sr.

Address: Westminster Md Route 6

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5 1945 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Hanover Road

18. Funeral director: D. D. Hesson & Son

Address: Union Bridge & New Windsor Md

19. 12-6-1945 (Date received by registrar) Ernest Bucket Registrar

E. M. Farver LR

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1945 at 5:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/2 1945 to 12/3 1945 and that I last saw h[illegible] alive on 12/3 1945

Immediate cause of death	DURATION
Uremia; dehydration	1
Due to Obstruction of bowel (1)	5
Due to Carcinoma of bowel (2)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. L. Seigman M. D. or other

Address: Union Bridge Date signed 12/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

12164

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 203 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clara F. Zahn

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years	Months	Days	If less than one day
about 78			hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER — 12. Name: Jacob T. Zahn

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Not known

MOTHER — 15. Birthplace: Germany

16. Informant: Roy L. Zahn

Address: Frizzellburg, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12/24/45 (month) (day) (year)

Cemetery or crematory: Krider's Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 12/23/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1945 at 2 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 1945, to Dec 22 1945 and that I last saw her alive on Dec. 22 1945

Immediate cause of death	DURATION
Heart disease with fibrillation	2 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Reese Wilkens M. D. or other

Address: Westminster Date signed: 12/23/45